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The Office of Personnel Management: A Power Player in America's Health Insurance Markets?

The Honorable Linda Springer, The Honorable Donald J. Devine, The Honorable Dan G. Blair, and Robert E. Moffit, Ph.D.

Abstract: *On Christmas Eve 2009, the U.S. Senate passed a mammoth health care bill that would dramatically expand the role of the U.S. Office of Personnel Management (OPM). Why should Americans care about this? OPM is the government agency that runs the federal civil service and also administers the Federal Employees Health Benefits Program—and does a decent job at both. But with its new powers, OPM would no longer merely act as referee in the annual competition among private health plans trying to attract federal workers. OPM would become the* official sponsor *of at least two national health plans (read: public option) that would compete against private plans in every state in the country. The possibility of OPM's new role opens up a near-endless array of questions and concerns. In a panel discussion on January 20, 2010, hosted by The Heritage Foundation, four health policy experts, including three former OPM directors, address some of them.*

ROBERT E. MOFFIT: Contrary to media reports on the 2,700-page Senate health bill, the prospect of a "public option" or a government-run health plan to compete against private health insurance is very much alive. The massive Senate health bill that passed on Christmas Eve ostensibly does away with the public option. In fact, it doesn't. It substitutes the traditional "public option" with something only apparently different: a new role for the U.S. Office of Personnel Management (OPM) as a power player in America's health insurance markets. As you all know, OPM is the feder-

Talking Points

- As an employer, the Office of Personnel Management (OPM), the government agency that runs the civil service, has enormous authority over rates and benefits for health plans in the Federal Employees Health Benefits Program. Applied to the federally re-designed private health insurance markets under the massive Senate health bill now before Congress, that authority would expand.
- OPM's current role would change to that of official *sponsor* of at least two national health plans that would compete directly against private health insurance across the country. These government-sponsored health plans would become, in effect, the "public option" that sponsors of the Senate bill claim to have rejected.
- OPM's new *external* role as a major player in the nation's health insurance markets would compromise OPM's current role as the federal agency tasked with administering *internal* federal programs.
- This duality of OPM functions has not been subjected to the normal vetting of legislative hearings and debate, despite its enormous impact on Americans.

This paper, in its entirety, can be found at:
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al agency that runs the federal civil service; it enforces the civil service laws and the rules and regulations. It also administers the Federal Employees Health Benefits Program (FEHBP), the largest group health insurance plan in the world.

The Senate bill includes a provision, Section 1334, which would give the OPM a very new and expansive role in the health care sector of the American economy. Right now, in administering the FEHBP, broadly speaking a defined contribution program of health insurance financing for federal workers and retirees, the OPM basically sets the rules of the game and serves as an umpire among private competing health plans. It enforces a common set of rules and oversees the administration of the payment in FEHBP, particularly on behalf of retirees.

The Senate bill gives the U.S. Office of Personnel Management a new responsibility: to sponsor at least two health plans that would compete against private health insurance in the state-based health insurance exchanges, potentially in every state of the Union. OPM has never done anything quite like this before.

Today, we have three former OPM directors to talk with us about this development in the Senate—this new health policy provision and the future role of OPM. Linda Springer, our first speaker, served as the eighth director of OPM from June 2005 to August 2008. Before becoming director of OPM, Linda held the position of controller at the Office of Management and Budget (OMB). She was also head of the Office of Federal Financial Management. Before her career in public service, Linda spent more than 25 years in the financial services industry in executive roles responsible for general and financial management and strategic planning. Linda received her Bachelor of Science degree, *cum laude*, from Ursinus College, and attended Columbia Business School. She is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

Our second speaker is Dan Blair. Dan served as the first chairman of the Independent Postal Regulatory Commission. He held that position from December 2006 through August 2009. The United States Senate unanimously confirmed Dan as commissioner of the Postal Rate Commission; he was designated chairman by President George W. Bush in December 2006. His current term as a commissioner expires in October 2012. Before coming to the commission, Dan served as deputy director of OPM. He was nominated by President Bush in December 2001 and confirmed by the U.S. Senate in February 2002. In addition to serving as deputy director, Dan was acting director of OPM for five months.

Finally, we have Dr. Donald Devine, former director of the OPM under President Ronald Reagan. Don is currently the senior scholar at the Bellevue University Center for American Vision and Values. Don was director of OPM from 1981 through 1985. He had advised President Reagan on political matters as early as 1976. He was also a senior advisor to Senator Robert Dole, and also to Steve Forbes, in their presidential campaigns. For 14 years, Don Devine was an associate professor of government and politics at the University of Maryland. He is the author of seven books on politics and political science.

—Robert E. Moffit, Ph.D., is the director of the Center for Health Policy Studies at The Heritage Foundation.

LINDA SPRINGER: Thanks to The Heritage Foundation for a very timely forum. Some people asked me last night if Heritage was still going to have this panel today in light of the election of Scott Brown, the new senator-elect from Massachusetts. It's easy to answer that question. The Senate bill takes on even more prominence in light of that election result.

The other thing that's interesting is that today, if you have not already realized, is January 20. Think about what you were doing one year ago today. Not too far from here many of us were waiting on Pennsylvania Avenue for the parade, or following the swearing in of the 44th President. So, a lot has happened in one year. And the Office of Personnel Management—it is always important, by the way, to mention that name in full, because some people think OPM means "other people's money"—will potentially take on a new role. OPM is not just an office; it is a full-fledged federal agency with many roles.

I'd like to talk a little bit about those roles; give a little bit of a primer for a few minutes about OPM. A lot has happened in this year and it has certainly thrust OPM into a position that I don't think anyone could have envisioned.

Let me name a few very important things to set the stage for understanding what OPM is, how it got into this particular position, and what the impact on the federal workforce will be if the Senate bill, or something close to it, becomes law. OPM is really a collection of a number of enterprises, businesses, and functions. Bob Moffit mentioned a few of them. Obviously the Federal Employees Health Benefits Program (FEHBP) falls under the purview of OPM. But that is just one of many benefit plans that OPM administers. I am sure there are people here who are covered by those plans, either as current employees of the federal government or as former employees, possibly retirees.

More than 8 million people are served by the Federal Employees Health Benefits plan—I should say program, because it is a collection of plans: somewhere between 250 and 300 each year—where OPM as an employer negotiates to get health coverage for its employees or its coverage group, meaning the federal workforce and dependents and retirees and others. OPM does many of the exact same things that any other employer does: due diligence over the health plans, issuing a call letter to the plans each year outlining what the employer, in this case OPM, wants in health benefits packages; making sure the plans meet certain requirements; undertaking negotiation of rates with those plans; and then ultimately having the annual "open season" just like any other big company does so that employees have the ability to understand their options and their health plan choices.

OPM's role is unique only because the FEHBP is so large. But other than that, it doesn't really do anything much different than any other employer. It is important to understand what OPM does not do. It is not in the insurance business; it does not underwrite the risks of the competing plans; it does not do the things that an insurer does. It certainly isn't running a public plan; it's just providing coverage the way any other large employer would, except that in this case its employees are employees of the federal government. It does a good job at that. The men and women who administer that program, just like the others at OPM, are dedicated to what they do, they take great pride in what they do, and they do it well.

OPM has other roles. For example, OPM does background investigations for 90 percent of those who require those investigations or renewals of the investigations. That includes contractors, current employees; altogether, more than 2 million background investigations are done by OPM. A major part, in fact, I would say roughly half of the OPM employee staffing, is dedicated to that background investigation function.

OPM is in the higher education business. It runs an Eastern and a Western Management Development Center, training those in the upper GS levels for their roles; it also runs the Management Development Center down near Charlottesville. There are roughly 10,000 to 13,000 people from the federal community each year who go through that system.

OPM obviously has a very strong role in the hiring process. USA Jobs is run by OPM. While OPM is not a central hiring agency, OPM obviously is integrally involved in the policies and procedures of hiring; it works with the federal agencies on requirements as they do their hiring. That is obviously an area that needs continued attention.

OPM is involved in oversight of agencies in compliance with personnel policies that are issued by OPM or that may have been enacted by Congress or the other parts of the executive branch. OPM is a compliance agency; it makes sure, for example, that the federal workforce is operating in an environment that adheres to merit systems principles.

OPM has many, many roles, and there are others that I haven't mentioned. That is the OPM of today. The question now becomes, what is the OPM of tomorrow if a bill like the Christmas Eve Senate bill passes? Clearly, I think we can say that that is still very much at play.

So, we need to look at some of the roles that OPM would have, what would they be, how would OPM be affected, and more importantly, how would the workforce be affected should the Congress put OPM into that position. Clearly, it would be very different than what it is today. Now, there are others

here who will go into more detail into what some of the requirements are. But suffice it to say that OPM was chosen—why?—to leverage the Federal Employees Health Benefits Program experience and knowledge that it has today.

So think about that. What does that mean? What are you leveraging? You are leveraging the knowledge of the people who run that program, ostensibly. You didn't pick the Interior Department, you didn't pick the Department of Defense, you picked OPM. Why? To leverage that knowledge. Where does it come from? The people. That is where it resides. So, to get that knowledge into some new program, administering new plans in a health insurance exchange, would require that those people devote at least some measure of their time to that new task. Whatever time they spend on the exchange program, they are not spending on the Federal Employees Health Benefits plan and their existing work today. So, to say that there would be no impact on the FEHBP, or to say that there are going to be additional resources so that the FEHBP is going to be left untouched, I think is at odds with the fact that you are leveraging the knowledge and experience of the very staff that is already there managing the FEHBP.

That is one type of impact. You look at other parts of the organization—this is not just about the FEHBP staff, it is also about the Inspector General (IG) staff. Who is going out to examine today the plans and providers that participate through those plans, providing the coverage under the existing federal plan? It is the IG's office of OPM. I can tell you from my time at the agency, and I doubt that it has changed, that the Inspector General office is subject to the same budget pressures as every other part of OPM. OPM is like other domestic agencies, and those budget pressures have had a downward impact. Staff groups come during each budget season each year and say: Could we have more money to do what we do? And the reality was that in many cases they get less.

Adding this new responsibility to oversee OPM's management role in a new federal health insurance exchange program onto the Inspector General creates a tremendous workload that I have not heard anywhere addressed. There are the other offices, the Office of General Counsel, the Office of Congressional Affairs; I would venture to say that there is very little, including the director's time, that will not be impacted in some way. It is a zero-sum game. There are only so many hours in the day. The time that OPM staff is spending on the important initiatives for the workforce today to some degree will be diverted to this new health insurance exchange program embodied in the Senate health bill. Is that good or is that bad? That is the question that has to be answered. But clearly one group that has to answer that question is the federal workforce and the retirees and all the other groups that OPM currently serves—millions of people.

The question I would put to those of you who are following this issue is this: Is the federal workforce best served by having an OPM that is dedicated to its mission of ensuring that the federal workforce is effective and has all its needs met? Or do we want an OPM that not only has that responsibility, but also has this additional big thing on the side—administering a program to cover the uninsured of the country? These are two very, very different things; and an unusual combination. Were it not for the OPM administration of FEHBP, one would never even think they go together. But really, is the federal workforce best served (A) as it stands, or (B) under this Senate scenario?

DAN BLAIR: I served as the deputy director of OPM from 2002 to 2006, and was also acting director for five months. Before that, I worked on Capitol Hill for 17 years. I worked four years in the U.S. Senate on what was then the Governmental Affairs Committee doing OPM oversight for then chairman and Senator Fred Thompson (R–TN). Prior to that, I worked on the House Government Reform and Oversight Committee as well, and on the old House Post Office and Civil Service Committee. So, I am very familiar with OPM and its strengths and weaknesses.

We are here today to talk about the Senate's proposed role for OPM in its health insurance exchange program and the Federal Employees Health Benefits Program. Many questions have been raised about how an OPM-directed health exchange program could or would work. I wanted to touch on four key points. Director Springer mentioned the impact on

OPM as an organization, and that is very, very important: how this new role will fit within the organization. Should Congress pass this version of the health care legislation and it be signed into law, it clearly will be an Administration priority; and as a priority, I would expect it to be funded fully and to have funding meet all of its resources needs.

If that is the case, what happens to the other programs at OPM? This question dovetails with how the Senate's new role for OPM fits into the mission of OPM. OPM's mission is to ensure an effective and efficient federal workforce, but this newly proposed federal health insurance program does not have anything to do with the federal workforce. OPM would be running a government-sponsored program in a federally mandated health insurance exchange for the uninsured, and to me, the two objectives do not seem to mesh very well. I am concerned what the impact will be on OPM's other programs.

Director Springer mentioned the security background checks, and Congress has frankly been quite critical of OPM over the years for not making sure that background and security clearance checks go more quickly. I know that has been a priority for the past Administrations and I presume it continues to be a priority for this Administration. How will that be impacted?

We have seen pay-for-performance systems killed at the Defense Department and also the Department of Homeland Security, and the Administration has talked about coming forward with new reforms for the civil service. How will these mesh and how will the resources be devoted for enacting and implementing new legislation when, in fact, OPM would also be tasked with a new and significant role in pushing forward this government-run program for the uninsured?

That comes back to a very basic question: What kind of federal health care program is this? I see this Senate program as nothing but a placeholder for the public option; and, as time goes on, I think that we will see the program evolve more into the public health insurance option that was originally proposed. But to me it is nothing but a placeholder for the public option. It raises questions of mission creep for the organization. Right now, OPM's mission is very broad, but it is limited to the management of the federal government. This Senate bill broadens it even more, and is it something that can work within its framework? I think these are questions that haven't been answered yet.

This provision creating a new role for OPM was put into the Senate bill after it passed the Senate Finance Committee. There have been no hearings on this; there have been no public testimonies on this. A number of serious questions have been raised: What will be the cost of this new federal program? More important, who bears the insurance risk in this program? What happens if health insurance premiums are set that do not cover the costs? Who will pick up the change? Will the taxpayers be at risk here? There are a number of unanswered questions which I believe need to be answered before we go forward with this kind of proposal.

So, there are many more questions being raised and thus far very few answers with this proposal. It seems to me that ladling this new responsibility onto OPM is going to be putting a very, very tough job on an organization that is already commanded to do many things throughout government. I would raise those questions and I would like to see answers to those before it moves forward.

I think that OPM has performed an exemplary role in managing the FEHB program, but that success does not necessarily translate to success in running a public option.

DONALD DEVINE: *The Washington Post* used to run stories on me all the time. One time there was a big picture of me on the front of the Sunday magazine with the title, "The Boss," and then, under it, "Reagan's Terrible Swift Sword of the Civil Service." President Reagan called me up and said, "Don, I got a job for you." I said, "What is it?" He said, "OPM." I said, "Opium?" "No, OPM." I said, "Well, what do you want me to do with it?" He said, "Well, I want you to reduce the number of non-defense civilian employees by a hundred thousand; I want you to cut back on bloated benefits; and I want you to make them work better; some kind of pay-for-performance system." I said, "Thanks a lot. I'm going to make a lot of friends in this job."

But I always remember what Harry Truman used to say about doing a tough job in Washington: "If you need a friend in Washington, buy a dog." So I

bought two to be on the safe side. And actually, at OPM we did what President Reagan wanted. We cut back non-defense civilian employment by a hundred thousand and saved about $6 billion—which used to be real money—on the benefits program, and we did introduce pay-for-performance, which I give President Carter the real credit for setting up, but we were allowed to implement it. I actually think the thing worked pretty well for awhile.

As far as the Federal Employees Health Benefits program, one of the first things that happened when I walked in was that they told me: "You have a shortfall of $440 million. There was an election year last year and the Democrats didn't want to increase the premiums enough to alienate one of their key constituencies, mainly the unions, so we've got to make it up this year." I said, "Well, what are the consequences?" The career staff at OPM briefed me on the problem, and added, "There's a thing called the Anti-Deficiency Act that you can go to jail for this deficit if you don't settle this."

That was kind of my introduction to this thing called the FEHBP. The staff at OPM said, "You have to do something about this," and I said, "Okay, tell me about my authority here." They said, "You can do anything you want. You negotiate the contracts." I said, "What? I can do anything I want on this?" They said, "Yeah! You can go out and bargain any kind of contracts you want." You know, I used to be a health insurance claims examiner way back in my nefarious youth, which is one of the reasons why they considered me qualified for the job, and I said, "You know, most of these plans don't have any deductibles or co-insurance; that's not insurance."

So, I said, "The first thing we're going to do is have mandatory deductibles and co-insurance." Boy, that got a hot reception, especially from the union plans and Blue Cross Blue Shield. They went crazy about this. I checked back with the staff, and said, "You sure I got the authority?" So, I did it.

The next thing I did—I got rid of abortion coverage in the FEHBP. Why should the taxpayers have to pay 75 percent of the abortion coverage on this thing? I also wanted to get more plans in the program. Of course, I ran into some stiff opposition. The plans already in did not like a lot of competition; they liked as many as were in the program, but they did not want any more. So I let additional health plans in and I set a policy that they must all have uniform rules for everybody, including the union plans. They did not like that very much either because they thought they were bargaining these plans, just like they do in the private sector.

That is what I did with this program. It was controversial. It went all the way up to the Supreme Court. The Court said I had the power to do what I did.

Now, let's look at the Senate health bill. When Bob Moffit first asked me about this, he said, "Take a look at this." I said, "What does this say?" Well, Section 1334 subsection A instructs the director of OPM to contract with insurers to offer "multi-state plans through each exchange in each state and to negotiate with each plan a medical loss ratio" (That means you decide how much goes in and out.), "a profit margin" (That's even better than the power of the old OPM.), and "profit margin premiums and other such terms and conditions of coverage as are in the interest of enrollees in such plans" (That's open-ended. You can do anything.). By the way, in Section E, notwithstanding paragraphs one and two of subsection B, the director is given even broader authority in managing the government-sponsored health plans—so most of the restrictions that apply to all the other exchanges, the local ones, do not really apply to the director of OPM.

This is incredible power to give somebody over the health care of the people of the United States. As Dan Blair said, this is clearly the substitute for the public option under another name. This is what the Senate sponsors really want, and of course it will disrupt the normal operations of OPM. I will put it this way, especially for those of you who know me and were around during my tenure: Do you really want to put me in charge of your medical program and potentially for everybody in the country? Now, maybe some people liked what I did, but a lot of people did not, and a lot of people would not. But this is an awful lot of power in the hands of one official.

Let's face it. Most of the time there will be nice people like Linda Springer and Dan Blair in the job of running OPM. But occasionally a President is going to come in and say to the OPM director, "Do

these things; and we don't have any money to fool around." When government budgets get tight, health benefits can get cut. Do you really want to give that kind of authority to anybody? That is my question.

BOB MOFFIT: That is a very interesting point of departure. We keep forgetting an obvious fact: This provision in the Senate bill has never been subjected to a hearing; champions of this proposal have never been subjected to the kind of tough cross-examination in House or Senate committees; none of the authorities with any expertise whatsoever in the functioning of the Federal Employees Health Benefits Program or the functioning of OPM have ever testified on Section 1334. This was something that was made up on the fly, with little or no serious discussion, and yet may very well become a central feature of the health care system of the United States.

I agree with my colleagues at Heritage that, in fact, this OPM provision in the Senate bill is the public plan in disguise. The contracting power of the director of OPM over FEHBP plans is enormous, and this provision would expand that power. When Don Devine was director, I was OPM's congressional relations director, and I can assure you that going up to Capitol Hill to deliver controversial news was, to put it diplomatically, an exciting and challenging experience. If something like this Senate provision is enacted, giving OPM such power in the health insurance markets, most of the time a future OPM congressional relations director would have to deal with a lot more than the House Government Operations Committee or the Senate Governmental Affairs Committee, or the House and Senate subcommittees that deal with Treasury-Postal Appropriations.

The new job of the OPM congressional relations director would cover a vast amount of new territory: the Senate Finance Committee, the Senate Health, Education, Labor, and Pensions Committee, as well as the House Energy and Commerce Committee, the House Ways and Means Committee, and the House Education and Labor Committee. That is what we are talking about on the ground, on the Hill, in the real world. We are not talking about the little old OPM of the past. This is something very big, and very different. Federal workforce issues will take a seat in the back of the proverbial bus. Bet on it.

The OPM is an agency of the White House; the Director of OPM reports to the President of the United States. In the Senate health bill, there are clearly regulatory differences between OPM and the Department of Health and Human Services (HHS), whether they are intentional or simply a drafting error is, at this point, anybody's guess. But remember one thing: If there is any conflict over how health insurance is to be treated between OPM and the HHS, all of those conflicts and issues will be decided in the West Wing of the White House. So, we are also talking about a tremendous transfer of authority to the President of the U.S. in terms of health care. We cannot overlook this direct line of authority, or forget who the director of OPM is. It is vitally important that Americans understand the importance of this powerful agency. It is a powerful agency within its own sphere, as many of us have come to learn. We are giving it new power and expanding its reach in a very dramatic way.

Questions & Answers

QUESTION: In the early 1990s, the National Social Insurance Retirement System, also known as Social Security, got into financial trouble. State and federal employees were made eligible for Social Security to help with the financing; thus was born the Federal Employees Retirement System (FERS), in which we lowered the defined benefit piece, expanded the thrift fund and integrated it with Social Security. If this is indeed a public plan that you see evolving in OPM, what prevents the same thing from happening if it gets into financial problems 10 years or so down the line?

DAN BLAIR: Well, I think you bring up a very good question, and that is: Who bears the risk in this? If premiums are set too low and costs are too high, who's going to make up that difference? And what's the impact going to be on the FEHBP? Now, the Senate enacted what I called "hold harmless" language; it said it's supposed to be operating as a separate program. But I don't see how you separate the two. They wanted to leverage the expertise for managing the FEHBP into this program. So, I think you bring up a very good point of how you actually keep

these programs separate. More importantly, who bears the risk in this program? And if it's not priced appropriately, who's going to have to bail it out?

DON DEVINE: Nice little language in the bill. Consider also that in Section 1334, the Senate authorized OPM to spend "such sums as may be necessary to carry out the obligations of this section." So it's open-ended. The concern is that taxpayers will have to pick up the cost of any of the problems.

BOB MOFFIT: Some folks have said that the language Dr. Devine refers to simply refers to the costs of the administration of this new program. But here's the problem: If you look at the original House bill (the so-called "Tri-Committee" bill) creating a public plan, there was specific language dealing with a level playing field and limitations on funding streams. That language gave the original House bill a patina of fiscal responsibility. When I testified before the Education and Labor Committee last June, I got into a spirited exchange with Congressman Robert Andrews of New Jersey on precisely this point of the level playing field and taxpayer liability, the point that Dan Blair raises. In the original House health bill, the sponsors specified that there would be a level playing field between the public option and private health plans. But in Section 221 of the original House bill, there is a provision that says the Secretary of HHS may contract with private entities to carry out the administration of the public plan. Now, that clearly means, in my view, something like the Medicare private contractors. You all know that the Medicare bureaucracy doesn't actually deliver Medicare benefits; Medicare officials enter a contract with private health insurance companies like the Blues or Anthem to deliver Medicare benefits in every part of the country.

But in entering into such contracts with private entities, Section 221 of the original House bill specified that in any contractual arrangement, the HHS Secretary may not transfer insurance risk to the carrier, which means that the taxpayers assume the risk. That, I thought, was a key point in the hearing before the Education and Labor Committee about who is ultimately stuck with the bill.

Now, in this Section 1334, there is absolutely no language at all on the crucial question of insurance risk or who's ultimately responsible for bailing out the multi-state plans if they run short. That's very troubling. It could be an oversight. But I doubt it.

QUESTION: I assume that if you undertake the role of negotiation explicitly determining the profit margin for one of your vendors, i.e., carriers, would you not then be bound to that same ratio and profit margin across all of your vendors? Or could you discriminate based on who you liked and who you didn't like?

BOB MOFFIT: The rules that govern all private health plans in both the House and Senate bill are basically set by the Secretary of HHS. In this particular case, in Section 1334 of the Senate bill, the language provides OPM independent authority over not only profit margins, but also medical loss ratio and premiums. Because it appears to provide separate regulatory authority for OPM, that means right away you don't have exactly the same statutory playing field where the other private plans are level with the OPM-sponsored multi-state plans. So, it's a troubling statutory situation.

LINDA SPRINGER: And one other thing: You get into that issue of whether a director of OPM takes on a role of arbitrarily saying you're going to make this money, Company A; and Company B, you can make this much money. Is that the OPM's role? Should that be OPM's role? This isn't something that even the state regulatory entities would take on in that way. So I don't recall seeing anything in Section 1334 that directly addresses that, or would prohibit it. It's a very fair question.

What's telling is that we're asking this question in a Heritage Foundation forum. I don't recall ever seeing that question asked in any other hearing or setting or any other discussion of this—certainly not in any other public forum, or in the legislative arena.

You've pointed out a prime example of why this discussion is so important. Is that really what the Senators would want OPM to do? Is OPM even qualified to do that? Does OPM become the regulator *de facto*? There are so many other things related to these questions. I came out of the life insurance business years ago. Bob Moffit mentioned that I'm an actuary. The whole notion of loss ratio, how much revenue goes to benefit payouts and how much for administration and other costs, gets to the

heart of the viability of those companies. Is OPM going to be in that driver's seat of having that much influence over the viability of these insurers? It's a fair question.

QUESTION: What does OPM currently negotiate with health plans in FEHBP, and how would that be different under the Senate multi-state plan?

LINDA SPRINGER: OPM negotiates the same thing that any other employer would. They're negotiating premium rates first and foremost and negotiating over certain benefit provisions and the pricing of those new provisions. For example, if you would like to include hearing aid coverage, what would that cost? Deductibles, co-pays; all of the things that any of us in a health insurance plan looks at each year. During "open season," you as a consumer get that notice about what has changed. We've added this feature, we've taken out this feature, we've expanded something, we've raised a price, we've lowered the price. Those are the things that are the subject of negotiation each year.

One thing I want to add, referencing Bob's comment about the White House role during our tenure: We were never directed by any White House office to influence us to do anything with respect to those negotiations. They would say, "We're interested in promoting health information technology, for example, so include that in your discussion and let us know if any of the carriers can make some inroads there." But they were never involved in any OPM negotiation, they never directed our negotiation, they never influenced our negotiation. They could have, but they never did. A fair question is would that change in this new model?

But to answer your question very directly: It's things like the premiums, the coverage levels, deductibles, co-pays, things like that, as well as new provisions.

DAN BLAIR: I also want to make another point clear: We don't negotiate payments to the providers, doctors, and hospitals. That's all done by the private carriers. Linda hit on a strong point. I had the privilege of working under two directors, Kay Coles James and Linda Springer, and both were very adamant in making sure that this program was run well. Now, every director has had his or her priorities, and those priorities are influenced and directed to a large degree by the White House. But there are concepts such as Linda mentioned: health information technology, health savings accounts; in the Clinton Administration there was the inclusion of mental health care parity. But I don't know what this new provision in the Senate health bill is going to hold for OPM's relationship with the White House. I don't know what the level of influence will be.

The FEHB program is set up under Title 5 of the U.S. Code and provides certain levels of benefits and a great deal of discretion to the director. This new plan to me seems to leave it very, very, very open-ended as to what the OPM-sponsored plans will look like. I also have a question about cross-subsidies between the health plans. Although they are mandated to operate separately, what does separately mean, and what does it mean if you have a participating plan in the insurance exchange and a participating plan in the FEHB? Will there be pressure put on one to raise rates higher in one plan in order to bring in more enrollees under the other? Given the high level of political attention given to this new insurance exchange, that's not an unfair question.

To answer your question about the negotiations, we have a set schedule for the program every year. You have the carrier conference, the call letter, the carriers submit their plans, you go through negotiations, and then in September the premiums are announced and you have open season at the end of the year. I don't know what this new program is going to look like, and we're on the precipice of it being enacted. If you are going to be this close to enactment, there are a lot of questions that need to be answered. After all, the American people are going to be subject to this new insurance program that will be nationwide.

DON DEVINE: It says in the legislation that one of the health plans has to be nonprofit, which itself is very interesting. Sounds like Blue Cross's lobbyist did a good job there. And one plan can't cover abortion, which presumably means one or more others can. It is interesting. It clearly implies much more involvement in running the plan than current OPM policy. When we set general rules, even though I've made some very definite policy decisions, there

were across-the-board requirements and everybody had to offer deductibles or co-insurance and nobody could cover abortion. So there were general rules. This one looks like you can do a lot of picking and choosing.

I also thought it was interesting that one of the things not under the control of the director is that plans have to offer the three-to-one age rating system. This means that health insurance premiums could be varied by age, but by no more than a three-to-one ratio. Some say that this is "getting rid of community rating." Community rating means that persons pay the same premium regardless of age. What they do is apply this three-to-one age ratio, which applies to everybody else, but what about federal employees themselves: What if this ratio is applied to them, and what would that do to the federal employees program? Would it not increase premiums for many of them substantially?

In any event, Bob Moffit suggests that the omissions in this thing might be purposeful. I would suggest they also may through omission be left wide open. Remember, this thing was thrown in the Senate bill at the last minute. I don't think it's well thought through, period. But that is, in some ways, worse than having bad effects because it leaves all of the questions up to whoever is administering the program. Depending on who you are, if it's Linda, it may be good; if it's me, maybe not.

QUESTION: Under the FEHBP, one of OPM's authorities is interpreting the contracts, including medical terminology. If a health plan turns down somebody, ultimately OPM interprets the contract to agree with the plan—something like experimental treatment. That's led to a tremendous amount of litigation that ultimately involves OPM. Could you comment on, politically and legally, where you see OPM ultimately as the one making what are going to be interpreted as medical decisions?

LINDA SPRINGER: I think that's an important question: What is OPM's role not only in respect to setting up the plans and negotiations and those types of things, but the actual administration under those plans with respect to claims and things like that? I don't think it's clear what it is. Is this something that's just going to solely be left to the insurers and their claims administration, or is there a role for OPM? It's of a significant magnitude greater than the size of the FEHB now, if it were for the whole uninsured population.

And then there is the issue of whether it could be subject to political pressures; you know as well as I that at OPM there were times when, for example, Members of Congress would weigh in and say, "I have a constituent who was just turned down for this type of coverage." If that happened in the national federal program, you can only imagine what would happen for all the uninsured.

But again, this comes back to the point that we've all mentioned in one way or another: There has not been a full vetting of this proposed arrangement. If I were the director of OPM, I'd be scared to death. I wouldn't want this role. Aside from how I might feel philosophically about whether this is OPM's role or not, it wouldn't be clear to me what my role actually is, and am I going to be expected to make those kinds of decisions and chart this territory? I don't think it's been vetted.

There are Members of Congress who had oversight of OPM who would come and say to me, "Linda, does this agency have what it needs to be successful? Are you getting the funding? I want the Government Accountability Office to come over and do a capacity study." And they've done it. You can look it up and see what OPM's mission is today. Regardless of how many dollars they throw at it or resources or people they might transfer from the Centers for Medicare and Medicaid Services over at HHS or whatever, the reality is it impacts OPM. I had occasion to talk to a senior political appointee at OPM a few months back in the current Administration. She said, "I never realized OPM did so many things." And that's the way it is right now. What's going to happen, what would she say about taking on this new role?

Could some of the things that are uncharted become political issues? What is OPM's role with respect to insurance claims? That's an open question, and that's scary.

DAN BLAIR: OPM's role since September 11, 2001, has changed dramatically. Anyone who was at OPM back then knows how much that event changed the agency. One of those new roles was

ensuring that the federal workforce could respond to these types of emergencies, and that was a priority. But how is that mission going to mesh with this new role of ensuring that the uninsured now have a new viable program of insurance, and that this is the right agency for those types of programs?

What I fear is that the attention paid to this new role will do short shrift to other important roles that OPM is playing—security checks, merit system oversight, hiring, compensation—a whole host of other programs.

For instance, in 2002, OPM implemented a new law mandating the establishment of a long-term care program. Part of the attractiveness to enrollees of that new long-term program was that we said to enrollees, "If you enroll today, your premiums will never increase." Well, because costs have gone up, because of other issues, OPM has proposed and is implementing a price increase—my premiums are going up 25 percent. And I'm upset by that. I was promised, I was among those who made that promise to enrollees that their premiums aren't going to go up.

If this kind of limited program has seen these kinds of problems, what kind of problems will this new nationwide program have? It's not directed at the federal workforce; it's directed at citizens at large.

QUESTION: The GAO reports that Medicare and Medicaid have an improper payments rate of 10 percent. Do we have any idea what the federal plan's improper payment rate is? Do we monitor it? And what would happen to that improper payment rate if you took on this whole new responsibility?

LINDA SPRINGER: The federal plan rate is very, very low. It's less than 1 percent. It's very tiny relative to the total dollars. That actually is one of the good points of that program from a fiscal standpoint. One wouldn't expect that that would change except to the extent that the oversight of the programs, partially by the IG's office, if its attention is diverted or its resources are taken away from their normal cycle of review, to now have to review what's going on in this proposed health insurance exchange arrangement. Then maybe that vigilance and that attention that they paid that led to that low rate could be diluted in some way.

But I think you're on to something, because it's not the same as the federal plan. It's going to be a different type of scenario. So, will the fiscal attention be provided for the improper payment? That's another fair question. There is a whole list of fair questions.

BOB MOFFIT: With regard to improper payments and the FEHBP, Linda's absolutely correct, and outside experts agree: They're very low. But remember this: When you're talking about improper payments or waste, fraud, and abuse in the FEHBP, you're talking about waste, fraud, and abuse at the expense of private health insurance plans that lose market share if they have too much waste, fraud, and abuse. So the private plans themselves have a direct and powerful economic incentive—unlike traditional Medicare—to police waste, fraud, and abuse in the FEHBP. My personal experience at OPM and studying the program is that it's a refreshing exception to the general experience of government health care programs.

QUESTION: You've all explained why there's a good chance that OPM's current functions will be affected, but what about the supposed firewall that the Senate language is supposed to have between this program and FEHBP? Do you believe that that firewall would be maintained, that all functions would be entirely separate? You made the point that the institutional knowledge of the staff in running the FEHBP is the reasoning behind the Senate proposal, but could you speak to the firewall in terms of the actual functioning of the two programs?

DON DEVINE: I find it impossible to believe that this modified community rating wouldn't be applied. I mean, how are they going to say everybody else in the world is covered by it and not the feds? I think inevitably what is done in the public plan or this OPM-administered exchange will probably seep over into the government employees' plans. Or if it doesn't, it becomes an even more impossible political situation for anybody who tries to defend it.

QUESTION: This is on the excise tax in the Senate health bill. If the current plan goes forward, there will be an excise tax on certain health insurance plans. Certainly some of those could be FEHB plans, and that will give OPM a new role of some-

how collecting and reporting those certain plans—hundreds of plans, millions of employees, many, many agencies—how will OPM administer that excise tax vis-à-vis the IRS, the insurers, and the employee? And how will you do the auditing, and a paper and reporting trail, to make sure everybody knows the proper level of taxation and whose plans might be subject to that?

DON DEVINE: I guarantee you nobody's thought of it.

LINDA SPRINGER: You hear nobody jumping to the microphone to answer that question. The reason is that it's not a question that has been addressed or really thought through. I think to the credit of the federal workforce, and those that are covered, and retirees and organizations that represent them—they're raising this issue. It's an administrative issue. Even if the only thing were the excise tax, and there was no public option or exchange or whatever you want to call it, that is an additional administrative burden for OPM. It is also an additional risk of payment or charge or increase in cost for the federal workers and retirees. It's an important thing to highlight.

DAN BLAIR: To add to the complexity of this, the Postal Service pays a higher percentage of the employer's share of the premium than regular federal employees in other federal agencies, so how do you go about factoring all of that in? The complex issues that you raise haven't been addressed yet, and that's precisely why we're up here raising them. Because we don't have answers.

LINDA SPRINGER: And it's not one plan. A lot of people will say, well, there's the federal plan (and even I once in awhile will slip into that), it's a program; it's a collection of plans. If you think about it, it's around 270 plans. Multiply what you have with one plan by 270. As you know, there are federal employees worldwide and they have to be able to have some sort of health coverage. That's why there are so many plans that are negotiated. And we also provide some range of choice so that someone in the far reaches as opposed to the national capital region has a health care option available to them. The excise tax will impose an enormous administrative burden.

There's one other way to look at this. I don't know how many of you had a chemistry course when you were in school, but I remember one of them. Teachers were trying to teach you that a solvent could only hold so much. And you kept putting things in and putting things in, and each solvent was a little different, but eventually you get to that point where you put one more grain of whatever that item is and everything falls out. It's not that the one just falls out, but everything comes out. Saturation point.

Are we getting to that saturation point with OPM? Senator George Voinovich said to me, "Do you have the capacity? Do you have what you need?" And I used to say, "Yes, but not a dime to spare." Is this that last grain that goes in that really disrupts everything, and everything starts to fall out? And is that good for federal workers? It's not a question for us even to answer. It's a question for the 8-plus million Americans covered by the federal plan, the 2.5 million retirees, the almost 2 million members of the federal workforce, and it's the Members and congressional staff. Because ultimately, that still is going to be OPM's mission. Even if you bolt these other things on, it's not losing its original Title 5 mission: to serve the federal workforce. Is that mission well served? Are those people, those constituents, well served if this Senate bill is enacted? Or is that the last item that goes into the solvent that makes everything start to be compromised?

DAN BLAIR: Or it's the other side of that coin. Does it cannibalize other programs and resources in order to make this one program, which is going to be the highest political priority, successful? And that's the biggest issue.

BOB MOFFIT: There's yet another way to look at this. The White House may decide for its own reasons—some future White House may decide—look, there's an institutional cultural problem at OPM. OPM is very, very friendly with private health care plans. They have these cordial and cooperative and sensitive negotiations every summer when a bunch of guys sit around the table and decide what the rates and benefits are going to be for the coming year. And then they have the open season in the fall and most of the time people are pretty happy.

But there's another possibility. Right now, Medicare does contract with private health plans. Medicare is a single-payer system, right? But how is it administered? It's administered *through contracts* with private health plans. So private plans basically become third-party administrators for the Medicare bureaucracy. What's to prevent the Administration, some future Administration, from saying, "Look, we need some serious, tough-minded guys over at OPM who are really going to drive things the right way in these health insurance markets. Let's deploy staff from the Center for Medicare Services (CMS) to OPM on a detail to manage the public plans, or what in fact would be a public plan, and undercut these profiteering private health plans?"

In fact, for Medicare Advantage, like Medicare Part D, which is a system of private competitive plans delivering prescription drug benefits, the Bush Administration wanted to make sure that the governance was compatible with that vision. The reason: CMS was not used to running a truly competitive type of system where you had private plans competing. So, they actually imported staff from OPM over into CMS to help administer the program, Medicare Advantage.

With the enactment of anything that looks like the Senate bill, you can forget the traditional way things have been done with the FEHBP. My view is that the powers given to OPM to promote a level playing field for competition among private health plans are substantively different from the kind of thing we're talking about with the Senate provisions. This is the sponsorship of health insurance by OPM in a competition against private health plans. That's a different animal.